Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout your *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can’t find a term you’re looking for or if you need more information than a definition includes, contact Member Services.

[*Plans should refer to other parts of the Member Handbook using the appropriate chapter number and section. For example, "refer to Chapter 9, Section A." An instruction* [*insert reference, as applicable*] *appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.*]

[*Plans should insert additional definitions not included in this model and exclude model definitions not applicable to your plan, your contractual obligations with CMS or enrolled beneficiaries. Plans should modify definitions as appropriate in the state and/or as directed by the state.*]

[*When plans use key terms in the Member Handbook, they explain the term in the first section where it appears along with a reference to Chapter 12*.]

[*If plans revise terminology (e.g., “Member Services” to “Customer Service”, “Care Coordinator” to “Care Manager”) that affect glossary terms, plans use the revised term consistently throughout the Member Handbook and alphabetize it in this chapter*.]

# Actions: These include:

# Denial or limited authorization of type or level of service

# Reduction, suspension, or stopping of a service that was approved before

# Denial of all or part of a payment or service

# Not providing services in a reasonable amount of time

# Not acting within required time frames for grievances or appeals

# Denial of member’s request to get services out of network for members living in a rural area with only one health plan

# Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

# Administrative law judge: A judge that reviews a level 3 appeal.

# AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

# Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

# Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of your *Member Handbook* explains appeals, including how to make an appeal.

# Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

# Biological Product: A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also “Original Biological Product” and “Biosimilar”).

# Biosimilar: A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (See “Interchangeable Biosimilar”).

# Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

# Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

# Care plan: Refer to “Individualized Care Plan.”

# Care team: Refer to “Interdisciplinary Care Team.”

# [*Plans with a single coverage stage should delete this paragraph*.] Catastrophic coverage stage: The stage in the Medicare Part D drug benefit where our plan pays all costs of your [*insert if the plan covers excluded drugs under an enhanced benefit with cost sharing in this stage for non-Part D drugs or other drugs:* Part D] drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent $<TrOOP amount> for Part D covered drugs during the year. [*Insert if applicable:* You pay nothing.] [*Plans that cover excluded drugs under an enhanced benefit with cost sharing in this stage or cost sharing for other drugs insert:* You may have cost sharing for excluded drugs that are covered under our enhanced benefit.]

# Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of your *Member Handbook* explains how to contact CMS.

# Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance”.

# Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

# [*Plans that do not have copays should delete this paragraph*.] Copay: A fixed amount you pay as your share of the cost each time you get certain [*insert if applicable:* services *or*] prescription drugs. For example, you might pay $2 or $5 for [*insert if applicable:* a service *or*] a prescription drug.

# [*Plans that do not have cost-sharing should delete this paragraph.*] Cost-sharing: Amounts you have to pay when you get certain [*insert if applicable:* services *or*] prescription drugs. Cost-sharing includes copays.

# [*Plans that do not have cost-sharing should delete this paragraph*.] Cost-sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the Drug List)is in one of [*insert number of tiers*] cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

# Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of your *Member Handbook* explains how to ask us for a coverage decision.

# Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

# Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

# Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

# [*Plans that do not have cost-sharing for Medicare Part D drugs should delete this paragraph. Plans may revise the information in this definition to reflect the appropriate number of days for their one-month supplies as well as the cost-sharing amount in the example*.] Daily cost- sharing rate: A rate that may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month’s supply.

Here is an example: Let’s say the copay for your drug for a full month’s supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7-day supply of the drug, your payment is less than $0.05 per day multiplied by 7 days, for a total payment less than $0.35.

# Direct access services: You can use any provider in our plan’s network to get these services. You do not need a referral or [prior authorization /service authorization] before getting services.

# Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

# Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

# [*Plans should include as appropriate*.] Drug tiers: Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of <insert number of tiers> tiers.

# Dual eligible individual: A person who qualifies for Medicare and Medicaid coverage.

# Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

# Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

# Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function [*SNBC should insert; insert as applicable:* (and if you are a pregnant woman, loss of an unborn child)]. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

# Emergency medical transportation: Ambulance services, including ground and air transportation for an emergency medical condition.

# Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

# Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

# Excluded Services: Services that are not covered by this health plan.

# External Quality Review Study: A study about how quality, timeliness and access of care are provided by <plan name>. This study is external and independent.

# Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy”, or “LIS”.

# **Family planning:** Information, services and supplies to help a person decide about having children. These decisions include choosing to have a child, when to have a child or not to have a child.

# Generic drug: A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It’s usually cheaper and works just as well as the brand name drug.

# Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

# Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

# Health risk assessment (HRA): A review of your medical history and current condition. It’s used to learn about your health and how it might change in the future.

# Home and Community-Based Services (HCBS): Additional services that are provided to help you remain in your home.

# Home health aide: A person who provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don’t have a nursing license or provide therapy.

# Home health care: Health care services for an illness or injury given in your home or in the community where normal life activities take the member.

# Housing Stabilization Services: Services to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing. The purpose of these services is to support a person’s transition into housing, increase long-term stability in housing in the community, and avoid future periods of homelessness or institutionalization.

# Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

* An enrollee who has a terminal prognosis has the right to elect hospice.
* A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
* We are required to give you a list of hospice providers in your geographic area.

# Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

# Hospital outpatient care: Care in a hospital that usually doesn’t require an overnight stay. An overnight stay for observation could be outpatient care.

# Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Member Services if you get any bills you don’t understand.

[*Plans with cost-sharing, insert:* As a plan member, you only pay our plan’s cost-sharing amounts when you get services we cover. We do **not** allow providers to bill you more than this amount.]

[*Plans with no cost-sharing, insert:* Because we pay the entire cost for your services, you do **not** owe any cost-sharing. Providers should not bill you anything for these services.]

# Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the Independent Review Entity.

# Individualized Care Plan (ICP or Care Plan): A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

# [*Plans with a single coverage stage delete this paragraph*.] Initial coverage stage: The stage before your total Medicare Part D drug expenses reach $[*insert initial coverage limit*]. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

# Inpatient: A term used whenyou are formally admitted to the hospital for skilled medical services. If you’re not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

# Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

# Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.

# Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

# *List of* Covered *Drugs* (Drug List): A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a “formulary”.

# Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don’t have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF).

# Low-income subsidy (LIS): Refer to “Extra Help”

# **Medical Assistance*:*** This is the name of Minnesota’s Medicaid program. Medical Assistance is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

* It covers extra services and some drugs not covered by Medicare.
* Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

# Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. Medically necessary care is appropriate for your condition. This includes care related to physical conditions and mental health. It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:

* be the services that other providers would usually order.
* help you get better or stay as well as you are.
* help stop your condition from getting worse.
* help prevent and find health problems.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

Medicare Advantage: A Medicare program, also known as “Medicare Part C” or “MA”, that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

# Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

# Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Medicare Part B.

# Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

# Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a “dually eligible individual”.

# Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

# Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

# Medicare Part C: The Medicare program, also known as “Medicare Advantage” or “MA”, that lets private health insurance companies provide Medicare benefits through an MA Plan.

# Medicare Part D: The Medicare prescription drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

# Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

# Medication Therapy Management (MTM): A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to Chapter 5 of your *Member Handbook* for more information.

# Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

# *Member Handbook* and Disclosure Information: This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

# Member Services: A department in our planresponsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Member Handbook* for more information about Member Services.

Minnesota Senior Care Plus (MSC+): A program in which the State contracts with health plans to cover and manage health care and Elderly Waiver services for Medical Assistance enrollees age 65 and over.

Minnesota Senior Health Options (MSHO): A program in which the State and CMS contract with health plans, including our plan, to provide services only for seniors eligible for both Medicare and Medical Assistance, including those covered by MSC+.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the state to provide health care services. We call them “network providers” when they agree to work with our health plan, accept our payment, and do not charge members an extra amount. While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

**Notice of Action:** A form or letter we send to you telling you about a decision on a claim, a service or any other action taken by our plan. This is also called a Denial, Termination, or Reduction (DTR).

**Nursing home certifiable:** A decision that you need a nursing home level of care. A screener uses a process called a Long Term Care Consultation to decide.

Nursing home or facility: A place that provides care for people who can’t get their care at home but don’t need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson’s services are free. You can find more information in **Chapters 2** **and 9** of your *Member Handbook*.

Open access services: Federal and state law allow you to choose any [insert as appropriate: physician or qualified health care provider], clinic, hospital, pharmacy, or family planning agency – even if not in our plan’s network – to get these services.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions”. **Chapter 9** of this *Member Handbook* explains coverage decisions.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

* You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
* Original Medicare is available everywhere in the United States.
* If you don’t want to be in our plan, you can choose Original Medicare.

# Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn’t cover most drugs you get from out‑of‑network pharmacies unless certain conditions apply.

# Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. **Chapter 3** of your *Member Handbook* explains out-of-network providers or facilities.

# [*Plans that do not have cost-sharing delete this paragraph*.] Out-of-pocket costs**:** The cost- sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. Refer to the definition for “cost-sharing” above.

# Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

# Palliative care: Palliative care helps people with serious illnesses feel better. It prevents or treats symptoms and side effects of disease and treatment. Palliative care also treats emotional, social, practical, and spiritual problems that illnesses can bring up. Palliative care can be given at the same time as treatments meant to cure or treat the disease. Palliative care may be given when the illness is diagnosed, throughout treatment, during follow-up, and at the end of life.

# Part A: Refer to “Medicare Part A.”

# Part B: Refer to “Medicare Part B.”

# Part C: Refer to “Medicare Part C.”

# Part D: Refer to “Medicare Part D.”

# Part D drugs: Refer to “Medicare Part D drugs.”

# Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

# **Physician services**: Health care services provided or coordinated by a medical physician licensed under state law (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine).

# **Prescription drugs:** Drugs and medications that can be dispensed only with an order given by a properly authorized person.

# **Primary care clinic (PCC):** The facility where you get most of the health care services you need, such as annual checkups, and helps coordinate your care. You may need to choose a primary care clinic when you enroll in our plan.

# [*Plans that do not use PCPs may omit this paragraph*.] Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

* They also may talk with other doctors and health care providers about your care and refer you to them.
* In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
* Refer to **Chapter 3** of your *Member Handbook* for information about getting care from primary care providers.

# Prior authorization (PA): [*Plans may delete applicable words or sentences if it does not require PA for any medical services or any drugs*.] An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don’t get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

* Covered services that need our plan’s PA are marked in **Chapter 4** of your *Member Handbook*.

Our plan covers some drugs only if you get PA from us.

* Covered drugs that need our plan’s PA are marked in the *List of Covered Drugs* and the rules are posted on our website.

# *[Minnesota plans do not include as there are no sites here]*Program for All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

# Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

# **Provider**: The general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the state to provide health care services.

# Quality of care complaint: In this handbook, “quality of care complaint” means an expressed dissatisfaction about health care services resulting in potential or actual harm to a member. Complaints may be about access; provider and staff competence; clinical appropriateness of care; communications; behavior; facility and environmental considerations; and other factors that can have a negative effect on the quality of health care services.

# Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Member Handbook* for information about the QIO.

# Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

# Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

# Referral: A referral is your primary care provider’s (PCP’s) approval to use a provider other than your PCP. If you don’t get approval first, we may not cover the services. You don’t need a referral to use certain specialists, such as women’s health specialists. You can find more information about referrals in **Chapters 3 and 4** of your *Member Handbook*.

# Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your *Member Handbook* to learn more about rehabilitation services.

# Restricted Recipient Program: A program for members who got medical care and have not followed the rules or have misused services. If you are in this program, you must get health services from one designated primary care provider, one clinic, one hospital used by the primary care provider, and one pharmacy. <MCO Name> may designate other health care providers. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months. The restricted recipient program does not apply to Medicare-covered services.

# State Appeal: If your doctor or other provider asks for a Medicaid service that we won’t approve, or we won’t continue to pay for a Medicaid service you already have, you can ask for a hearing. If the hearing is decided in your favor, we must give you the service you asked for.. You must ask for a hearing in writing. You may ask for a hearing if you disagree with any of the following:

# A denial, termination or reduction of service

# Enrollment in the Plan

# Denial in full or part of a claim or service

# Our failure to act within required timelines for [prior authorization/service authorization] and appeals

# Any other action

# State Medicaid agency: In Minnesota, this agency is the Minnesota Department of Human Services.

# Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it’s generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

# [*Insert if applicable*] Share of cost: The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

# Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

# Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

# Specialist: A doctor who provides health care for a specific disease or part of the body.

# State Hearing: If your doctor or other provider asks for a Medicaid service that we won’t approve, or we won’t continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

# Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

# Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits are not the same as Social Security benefits.

# Urgently needed care: Care you get for an unforeseen illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you cannot get to them because given your time, place, or circumstances, it is not possible, or it is unreasonable to obtain services from network providers (for example when you are outside the plan’s service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency).

[*Plans may add a back cover for the Member Handbook that contains contact information for Member Services or additional contacts as needed. Below is an example plans may use. Plans also may add a logo and/or photographs, as long as these elements do not make it difficult for members to find and read the contact information*.]

**<Plan name> Member Services**

| Type | Details |
| --- | --- |
| **CALL** | <phone number(s)>  Calls to this number are free. [*Insert days and hours of operation, including information on the use of alternative technologies.*]  Member Services also has free language interpreter services available for non-English speakers. |
| **TTY** | <TTY number.>  [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]  Calls to this number are free. <Days and hours of operation.> |
| **FAX** | [*Optional:* *Insert fax number.*] |
| **WRITE** | <address>  [***Note:*** *Plans may add email addresses here.*] |
| **WEBSITE** | <URL> |